

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-020826

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 211

Primary Registration District No. 4324

Registrar's No. 22-63

STATE FILE NUMBER

FILED JUN 13 1963

1. PLACE OF DEATH a. COUNTY <u>Miller</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miller</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tusculumbia</u>		c. CITY OR TOWN <u>Eugene</u>	
Length of stay in 1b <u>10 DAYS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Humphreys Hospital</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>TURNER</u> Last <u>TURNER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1917</u>
9. AGE (last birthday) <u>45</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDIANA</u>	
11. BIRTHPLACE (City and state or country) <u>U.S. America</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. America</u>	
13a. FATHER'S NAME <u>HiLray Ray</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie King</u>	
14. NAME OF HUSBAND OR WIFE <u>Charles Turner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>John E. Turner Eugene, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Lymphatic Leukemia</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>		20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>1961</u> to <u>May 28-1963</u> and last saw her alive on <u>May 28-1963</u> Death occurred at <u>5:47 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul Howard</u> (Degree or title) <u>Do.</u>		22b. ADDRESS <u>Tusculumbia, Mo.</u>	
22c. DATE SIGNED <u>6-8-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>MAY 30, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL</u>	
23d. LOCATION (City, town, or county) <u>Russellville, Mo.</u>		24. FUNERAL DIRECTOR <u>G.N. Steffens</u>	
25. DATE RECD. BY LOCAL REG. <u>June 10, 1963</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. D. E. Kallenbach</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

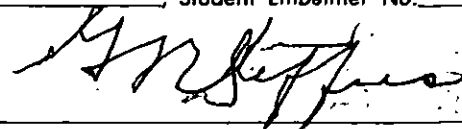
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.